Inpatient, Outpatient and Observation: Medicare Rules and Regs in Practice (Part 1)

Steven J. Meyerson, M.D., Vice President, Regulations and Education Group
Accretive Physician Advisory Service
RAC Regions
Medicare Requires Screening of Admissions

• “...screening criteria must be...used by the UM staff to screen admissions...

• The criteria used should screen both severity of illness (condition) and intensity of service (treatment).

• Cases that fail the criteria [for admission] should be referred to physicians for review.
“The hospital must have in effect a utilization review (UR) plan that provides for review of services furnished by the institution and by members of the medical staff to patients entitled to benefits under the Medicare and Medicaid programs.”

Code of Federal Regulations [Title 42, Volume 3] Sec. 482.30
Condition of Participation: Utilization review
(c) **Standard: Scope and frequency of review.**

1. The UR plan must provide for review for Medicare and Medicaid patients with respect to the medical necessity of (i) Admissions to the institution; (ii) The duration of stays; and (iii) Professional services furnished, including drugs and biological(s).

2. Review of admissions may be performed before, at, or after hospital admission.

Code of Federal Regulations] [Title 42, Volume 3] Sec. 482.30 Conditions of Participation: Utilization review
• “The reviewer shall use a screening tool [InterQual, Milliman] as part of their medical review of acute IPPS [Inpatient Prospective Payment System, i.e., acute care hospital] and LTCH [long term care hospital] claims.

• CMS does not require that you use a specific criteria set.

• In all cases, in addition to screening instruments, the reviewer applies his/her own clinical judgment to make a medical review determination based on the documentation in the medical record.”

Medicare Program Integrity Manual, Chapter 6, Section 6.5.1
InterQual: Objective screening criteria used by case managers to screen pts for admission.

- “Finding” = SI: severity of illness. How sick is the pt?
- “Treatment” = IS: intensity of service. What is ordered?
- Must meet both SI and IS criteria to “meet criteria” for admission.
  - Will qualify for observation if inpatient criteria not met and observation criteria are met.
- Refer to physician advisor (PA) for secondary review when admission criteria not met
- PA uses physician judgment and applies Medicare guidelines for admission, not InterQual criteria.
• Review indications for admission or observation
• Refer for physician advisor secondary review when uncertain or criteria not met
Admission review is often a two step process:
1. Review by case manager against objective criteria
2. Secondary review by physician to determine medical necessity for admission for those cases that fail to pass admission screening.

Failure to perform effective secondary review results in:
1. Missed admission opportunities
2. Lost hospital revenue
3. High observation rate
4. Lack of compliance with Medicare admission rules
“An inpatient is a person who has been admitted to a hospital for bed occupancy for purposes of receiving inpatient hospital services.

Generally, a patient is considered an inpatient if formally admitted as inpatient with the expectation that he or she will remain at least overnight and occupy a bed...

The physician or other practitioner responsible for the care of the patient at the hospital is also responsible for deciding whether the patient should be admitted as an inpatient.”
“Physicians should use a 24-hour period as a benchmark, i.e., they should order admission for patients who are expected to need hospital care for 24 hours or more, and treat other patients on an outpatient basis.” [BUT]

“Admissions...are not covered or non-covered solely on the basis of the length of time the patient actually spends in the hospital.”
“The decision to admit a patient is a complex medical judgment which can be made only after the physician has considered a number of factors:

- The patient’s medical history and the severity of the signs and symptoms which impact the medical needs of the patient and influence the expected LOS.
- The medical predictability of something adverse happening to the patient.”

Medicare Benefit Policy Manual – Chapter 1
“…[Reviewers should] consider only the medical evidence which was available to the physician at the time an admission decision had to be made, and do not take into account other information (e.g., test results) which became available only after admission.”

Medicare Intermediary Manual, Paragraph 3101
In making decisions, Quality Improvement Organizations (QIOs) consider only the medical evidence which was available to the physician at the time an admission decision had to be made. They do not take into account other information which became available only after admission, except in cases where considering the post admission information would support a finding that an admission was medically necessary.

CMS Benefit Policy Manual, Chapter 1
Inpatient Services Covered Under Part A
“The physician’s order must clearly define and state the level of care the patient requires. Suggested wording that may be used is ‘admission to inpatient status’ or ‘place patient into observation status.’”

Medicare Benefit Policy Manual – Chapter 1
“CMS updated … by removing references to "admission" and "observation status" in relation to outpatient observation services and direct referrals for observation services. These terms may have been confusing to hospitals.

The term "admission" is typically used to denote an inpatient admission and inpatient hospital services.”

Pub. 100-02, Medicare Benefit Policy Manual, Chapter 6, section 20.6
“Observation is a well defined set of specific, clinically appropriate services, which include ongoing short-term treatment, assessment and reassessment that are furnished while a decision is being made regarding whether patients will require further treatment as hospital inpatients or if they are able to be discharged from the hospital.”

Medicare Benefit Policy Manual, Pub 100-04, Chapter 4, Section 290
“Observation is an active treatment to determine if a patient’s condition is going to require that he or she be admitted as an inpatient or if it resolves itself so that the patient may be discharged.”

The Federal Register, 11/30/01, pg 59881
“Observation services are covered only when provided by the order of a physician or another individual authorized by State licensure law and hospital staff bylaws to admit patients to the hospital or to order outpatient services…”

“Observation services must also be reasonable and necessary to be covered by Medicare.”

Medicare Claims Processing Manual, Chapter 4, 290.1
“Outpatient observation services are not to be used as a substitute for medically necessary inpatient admissions.”

LCD for Outpatient Observation Services (L13798)
First Coast Service Options, Inc. (FL)
“Outpatient observation services are not to be used for the convenience of the hospital, its physicians, patients, or patient’s families, or while awaiting placement to another facility.”

LCD for Outpatient Observation Services (L13798) – First Coast Service Options, Inc. (Medicare FL)
• “An inpatient admission is not covered when the care can be provided in a less intensive setting without significantly and [directly] threatening the patient's safety or health.
• In many institutions there is no difference between the actual medical services provided in inpatient and outpatient observation settings; in those cases the designation still serves to assign patients to an appropriate billing category.”

WPS Medicare, LCD L32222
“Observation time begins at the clock time documented in the patient’s medical record, which coincides with the time that observation care is initiated in accordance with a physician’s order. Hospitals should round to the nearest hour.”

Claims Processing Manual, Chap 4, Section 290.2.2, Effective 7-1-11
“Observation services should not be billed concurrently with diagnostic or therapeutic services for which active monitoring is a part of the procedure (e.g., colonoscopy, chemotherapy). In situations where such a procedure interrupts observation services, hospitals may determine the most appropriate way to account for this time.”

Medicare Claims Processing Manual, Chapter 4 - Part B Hospital 290.2.2
Effective 7/1/2011
“For example, a hospital may record for each period of observation services the beginning and ending times during the hospital outpatient encounter and add the length of time for the periods of observation services together to reach the total number of units reported on the claim for the hourly observation services HCPCS code G0378 (Hospital observation service, per hour).”

Medicare Claims Processing Manual, Chapter 4 - Part B Hospital 290.2.2
Effective 7/1/2011
Active Monitoring: Use of Estimated Time

Good news!
“A hospital may also deduct the average length of time of the interrupting procedure, from the total duration of time that the patient receives observation services.”

Medicare Claims Processing Manual, Chapter 4 - Part B Hospital 290.2.2
Effective 7/1/2011
“Observation time may include medically necessary services and follow-up care provided after the time that the physician writes the discharge order, but before the patient is discharged.

However, reported observation time would not include the time patients remain in the hospital after treatment is finished for reasons such as waiting for transportation home.”

Medicare Claims Processing Manual, Chapter 4 - Part B Hospital
When Observation Ends

• “Observation time ends when all medically necessary services related to observation care are completed. For example, this could be before discharge when the need for observation has ended, but other medically necessary services not meeting the definition of observation care are provided (in which case, the additional medically necessary services would be billed separately or included as part of the emergency department or clinic visit).

• Alternatively, the end time of observation services may coincide with the time the patient is actually discharged from the hospital or admitted as an inpatient…”

Medicare Claims Processing Manual, Chapter 4 - Part B Hospital
“In only rare and exceptional cases do reasonable and necessary outpatient observation services span more than 48 hours.”

Medicare Benefit Policy Manual, Pub.100-02, Chapter 6 - Hospital Services Covered Under Part B  (Rev. 157, 06-08-12)
“Currently, we do not specify a limit on the time a beneficiary may be an outpatient receiving observation services, although, in the past, we have limited payment of observation services to a specific timeframe, such as 24 or 48 hours.”

CY 2013 OPPS Proposed Rule, July 2012
“In most instances, observation shouldn’t last for more than 48 hours,” Marilyn Tavenner, acting administrator of the Centers for Medicare and Medicaid Services said in a July 2 telephone interview.

“Patients staying three, four, five, six days is not the intent of observation,” Tavenner said. “Observation is designed for the first 24 to 48 hours. Beyond that, hospitals should make a decision about whether to admit.”

Bloomberg.com, 7/12/2010
“Medicare Fraud Effort Gives Elderly Surprise Hospital Bills”
After a patient has been in obs status for 48 hours (ideally after 24 hrs):

- **Discharge** if stable. (Continue eval and Rx as outpt.)
  or
- **Admit.** Document medical necessity for admission. (Q: Why can’t the pt be discharged?)
  or
- **Convert to outpatient in a bed.** Stop Obs billing (e.g., waiting for a test to be completed) -- UNDESIRABLE. No reimbursement for OPIB.
  or
- **Continue observation status.** UNDESIRABLE. Need to justify > 48 hrs in observation. No additional payment. May be denied as medically unnecessary.
Observation LOS Data

2006
• < 12 hrs - 17%,
• 13-24 hours - 43%
• 24 to 48 hours – 37%
• > 48 hrs - 3%
  CMS, 72 F.R. 66580, 66813 (Nov. 27, 2007)

2008: > 48 hrs – “nearly 6%”
  CMS letter to the American Hospital Association, July 7, 2010

2006 - 2008
• > 48 hrs – 8% → 12%
• # of obs claims ↑ 22%; ALOS ↑ 26 → 28 hrs
  MedPAC report to Congress, Sept. 13, 2010

2007 – 2010: > 48 hrs – 3% → 7.5%
  2013 OPPS Proposed Rule
“In cases where a hospital…UR committee determines that an inpatient admission does not meet the hospital’s inpatient criteria, the hospital or CAH may change the beneficiary’s status from inpatient to outpatient…provided all of the following conditions are met:

Medicare Claims Processing Manual, Chapter 1, Sec 50.3.2 (2006)
“…provided all of the following conditions are met:
1. The change in patient status from inpatient to outpatient is made prior to discharge or release, while the beneficiary is still a patient of the hospital;
2. The hospital has not submitted a claim to Medicare for the inpatient admission;
3. The practitioner responsible for the care of the patient and the UR committee concur with the decision; and
4. The concurrence of the practitioner responsible for the care of the patient and the UR committee is documented in the patient’s medical record.”

Medicare Claims Processing Manual, Chapter 1, Sec 50.3.2 (2006)
(d) **Standard: Determination regarding admissions or continued stays.**

(1) The determination that an admission or continued stay is not medically necessary:
   (i) May be made by **one physician member of the UR committee** if the practitioner or practitioners responsible for the care of the patient, as specified of 482.12(c), *concur* with the determination or fail to present their views when afforded the opportunity; and
   (ii) Must be made by **at least two physician members** of the UR committee in all other cases.

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Code of Federal Regulations [Title 42, Volume 3] Sec. 482.30
Condition of participation: Utilization review
(d) **Standard: Determination regarding admissions or continued stays.**

(2) Before making a determination that an admission or continued stay is not medically necessary, the UR committee **must consult the practitioner** or practitioners responsible for the care of the patient, as specified in 482.12(c), and afford the practitioner or practitioners the opportunity to present their views.

Code of Federal Regulations [Title 42, Volume 3] Sec. 482.30
Conditions of participation: Utilization review
(3) If the committee decides that admission to or continued stay in the hospital is not medically necessary **written notification must be given**, no later than 2 days after the determination, to the hospital, the patient, and the practitioner or practitioners responsible for the care of the patient, as specified in 482.12(c).

Code of Federal Regulations] [Title 42, Volume 3] Sec. 482.30
Condition of participation: Utilization review
“May a hospital change a patient’s status using Condition Code 44 when a physician changes the patient’s status without utilization review (UR) committee involvement?

No, the policy for changing a patient's status using Condition Code 44 requires that the determination to change a patient's status be made by the UR committee with physician concurrence. The hospital may not change a patient's status from inpatient to outpatient without UR committee involvement. The conditions for the use of Condition Code 44 require physician concurrence with the UR committee decision...”
“When the hospital has determined that it may submit an outpatient claim according to the conditions described above, the entire episode of care should be billed as an outpatient episode of care on a 13x or 85x bill type and outpatient services that were ordered and furnished should be billed as appropriate.”

Medicare Claims Processing Manual, Chapter 1, Sec 50.3.2 (2006)
“If the conditions for use of Condition Code 44 are not met, the hospital may submit a 12x bill type for covered “Part B Only” services that were furnished to the inpatient… Examples include, but are not limited to, diagnostic x-ray tests, diagnostic laboratory tests, surgical dressings and splints, prosthetic devices, and certain other services. (See Pub. 100-02, Medicare Benefit Policy Manual, Chapter 6, Section 10)”

Medicare Claims Processing Manual, Chapter 1, Sec 50.3.2 (2006)
“When patients with known diagnoses enter a hospital for a specific minor surgical procedure or other treatment that is expected to keep them in the hospital for only a few hours (less than 24), they are considered outpatients for coverage purposes regardless of:

• the hour they came to the hospital,
• whether they used a bed, and
• whether they remained in the hospital past midnight.”

Medicare Benefit Policy Manual, Chapter 1
Addendum E: Inpatient only procedures

“The inpatient list specifies those services that are only paid when provided in an inpatient setting because of the

• Nature of the procedure,

• Need for at least 24 hours of postoperative recovery time or monitoring before the patient can be safely discharged, or

• Underlying physical condition of the patient.”

April 7, 2000 Final Rules (65 FR 18455)
Inpatient only = Outpatient never
Addendum E: Inpatient Only Procedures

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Status Indicator C = Inpatient only

5 HCPCS codes (procedures) for “removal of gall bladder”
All inpatient procedures
Addendum B: Quarterly update includes all CPT/HCPCS codes.

Status indicators:

C – Inpatient only:

• Must be admitted *prior to* surgery.

• Hospital cannot bill if procedure is done as outpatient.

T – Outpatient procedure when done on stable patient *or* can be inpatient under certain circumstances.
### Addendum B

**Addendum B - OPPS Payment by HCPCS Code for CY 2011**

<table>
<thead>
<tr>
<th>HCPCS Code</th>
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<th>Relative Weight</th>
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**Legend:**
- **C** = Inpatient only
- **T** = outpatient / can be inpatient
- **APC** = ambulatory payment classification
- No APC for inpatient procedures
Where to Find the Lists

Addendum E: Inpatient only list (Only status indicator C procedures)

Addendum B: Quarterly update to OPPS list (Status indicators C and T)


Addendum B only:

http://cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Addendum-A-and-Addendum-B-Updates-Items/CMS1255194.html
“It is important … to ensure an inpatient admission order is present in the medical record to designate that the patient is an inpatient prior to the patient receiving the inpatient only procedure.

When a record is reviewed and the order was obtained after the inpatient only procedure, the procedure must be removed from the DRG grouping. The hospital will not receive payment for the procedure since the procedure will not be included in the DRG grouping [Part A] and cannot be billed under Part B.”

There is no APC code for an inpatient only procedure so it can’t be billed on an outpatient bill and hospital can’t get paid.

TMF Health Quality Institute (Texas QIO)
“The fact that the procedure is in an APC* group…should not be construed to mean that the procedure may only be performed in an outpatient setting… We (CMS) expect that when these (APC list procedures) are performed in the outpatient setting, they will be only the simplest, least intense cases.”

Federal Register, September 8 1998

*APC=Ambulatory Payment Classification, used to pay hospitals for bundled outpatient services
Any operation or procedure *not* on the inpatient only list must be done as an outpatient with the following exceptions:

- The patient is appropriately admitted for an unrelated reason.
- The presence of serious comorbidities justifies admission for the surgery (based on risk of adverse outcome).
- The surgeon plans to keep the patient in the hospital for > 24 hours for medically necessary post op treatment and/or monitoring (reason documented).
- The surgery is done on an emergency basis or on an unstable patient at risk for adverse events.
Inpatient Admission for “Outpatient Surgery”

- If an inpatient only procedure is planned for a patient in observation, the ED or other outpatient setting, the patient must be admitted prior to the procedure (admit before going into OR).

- If unplanned inpatient only procedure is done --either an outpt procedure was planned and changed to inpatient due to operative findings, or an outpatient procedure was planned with “possible” inpatient procedure -- the pt must be admitted immediately post procedure.

- A delay in admitting may result in the hospital being unable to bill for the inpatient procedure.
Hospitals should not report as observation care services that are part of another Part B service, such as postoperative monitoring during a standard recovery period (e.g., 4-6 hours).

Medicare Claims Processing Manual Ch 4, Section 290.2.2
Observation is restricted to situations where a patient exhibits an uncommon or unusual reaction to a surgical procedure ...and the condition requires monitoring and treatment beyond the treatment customarily provided in the immediate post operative period...and does not require inpatient admission.

Palmetto Medicare (LCD L1158) (Retired LCD)
“There must be medical necessity for observation beyond the usual recovery period, as hours of the usual recovery time associated with the procedure are already reimbursed with the procedure.”

Local Coverage Determination Policy (LCD#1281) issued by Blue Cross, Blue Shield of Tennessee (River Bend Government Benefits Administrator)
“Can a same-day surgery patient with no postoperative complications be admitted to observation?

No. There must be medical necessity of observation services documented in the medical record. Observation is not to be used as a substitute for recovery room services.

Can a patient be placed in observation status prior to outpatient surgery?

No. The need for observation care should be determined by the patient’s condition during the postoperative recovery period, not prior to surgery.”

TMF Health Quality Institute, Texas Medicare Q.I.O.
What does not qualify for outpatient observation?

- Routine stays following late surgery
- Outpatient therapy/procedures (unless there is documentation that the patient’s condition is unstable)
- Normal postoperative recovery following surgery
- Stays for the convenience of patient, family or doctor
- Stays prior to an outpatient surgery procedure
• “General standing orders for observation services following all outpatient surgery are not recognized. Hospitals should not report as observation care services that are part of another Part B service, such as postoperative monitoring during a standard recovery period (e.g., 4-6 hours), which should be billed as recovery room services.

• Similarly, in the case of patients who undergo diagnostic testing in a hospital outpatient department, routine preparation services furnished prior to the testing and recovery afterwards are included in the payments for those diagnostic services.”

Medicare Claims Processing Manual Chapter 4, Section 290.2.2
Indications for Post Op Observation

• Drug reactions
• Difficulty awakening from anesthesia
• “Other post surgical complication”

Medicare Benefit Manual
Indications for Post Op Observation

- Persistent nausea/vomiting
- Fluid/electrolyte imbalance
- Uncontrolled pain
- Dysrhythmias
- Excessive/uncontrolled bleeding
- Psychotic behavior
- Unstable level of consciousness
- Deficit in mobility/coordination

TMF Health Quality Institute, Medicare Q.I.O. for Texas
• “The beneficiary must be in the care of a physician during the period of observation, as documented in the medical record by outpatient registration, discharge, and other appropriate progress notes that are timed, written, and signed by the physician.

• The medical record must include documentation that the physician explicitly assessed patient risk to determine that the beneficiary would benefit from observation care.”

Medicare Claims Processing Manual section 290.5.1
“During any course of treatment rendered by auxiliary personnel, the physician must personally see the patient periodically and sufficiently often to assess the course of treatment and the patient’s progress and, where necessary, to change the treatment regimen.”

Pub 100-02 Medicare Benefit Policy Transmittal 128
Hospital OPPS Payment for Observation: 2012

- > 8 hours observation required for payment.
- APC 8002: $393.15
  - Direct admission to observation from physician’s office
  - Level 5 new or established patient hospital clinic visit on the day of or the day before observation: 99205, 99215
- APC 8003: $720.64 — Must have on the day of or day before observation:
  - Level 4 or 5 Type A ED visit: 99284 or 99285 or
  - Level 5 Type B ED visit: G0384 or
  - Critical care: 99291
- APC 8003 includes payment for ED visit.
  - The increase ranges from $391.10 for level 5 ED visit to $498.06 for a level 4 visit.
“If a hospital provides a service with status indicator ‘T’ on the same date of service, or one day earlier than the date of service associated with HCPCS code G0378, the composite APC 8003 would not apply…HCPCS code G0378 will continue to be assigned status indicator ‘N,’ signifying that its payment is always packaged.”

OPPS Final Rule 11/1/07, CMS-1392-FC
• Inpatient hospital stay – Medicare Part A: single deductible for first 60 days: $1,156 (2012)
• Observation – Medicare Part B
  • Outpatient deductible: $140/yr (2012)
  • 20% copayment for every service
    • No coverage for “self administered” meds: Billed at hospital rates. No limit. Can be very costly!
• 3-day stay rule for SNF placement: Obs doesn’t count
• Short LOS in Obs – patient may c/o feeling rushed out
• The right to receive appropriate LOC services.
• Confusion about coverage (“Wasn’t I admitted to the hospital?”)
2012: OIG Work Plan
We [the Office of the Inspector General] will review Medicare payments for observation services provided by hospital outpatient departments to assess the appropriateness of the services and their effect on Medicare beneficiaries’ out-of-pocket expenses for health care services…”

OIG Work Plan, 2012
Sample Cases: Inpatient, Outpatient or Observation?

- A 24 yo healthy woman is scheduled for elective hernia repair.
- A 72 yo man comes to the ED complaining of abdominal pain and diarrhea. His examination shows some tenderness w/o guarding. CT shows possible ileus. WBC is WNL.
- A 56 yo man with EF of 15% is scheduled for AICD placement.
- A 40 yo woman has urinary retention after elective lap chole.
- A 56 yo diabetic with hypertension and hyperlipidemia comes to the ED after a thirty minute episode of chest pain. ECG and CEs - WNL.
- An 88 yo woman with h/o CAD (MI 2 yrs ago), DM (recent BS 246), and COPD (nocturnal O2) is scheduled for lap chole.
- A 50 yo man with no medical problems comes to the ED with syncope after tennis. His exam and ECG are WNL.
- A 50 yo man with h/o CAD (PCI 3 yrs ago) comes to the ED with syncope while eating. ECG shows type 2 2nd degree heart block.
- A 90 year old man needs a bowel prep for colon surgery – can’t perform at home.
Rodney Dangerfield:  
“I never got any respect…  
When I was a child and we played hospital, the other boys and girls made me an outpatient.”

Appearance on Ed Sullivan Show
Contact Information:
Steven J. Meyerson, M.D.
Vice President, Regulations and Education Group (“the REGs Group”)
Accretive Physician Advisory Services (AccretivePAS®)
231 S LaSalle St
Suite 1600
Chicago, IL 60604
Cell: 305-342-7936
smeyerson@accretivehealth.com
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